DEPARTMENT OF CHILDREN AND FAMILIES
Division of Safety and Permanence

90-Day Summary Report for Child Death, Serious Injury or Egregious Incident

Reports submitted to the Division of Safety and Permanence (DSP) that do not include all of the required information will be returned to the agency for proper completion. Do not identify individuals by name when completing this report. Individuals may be referenced by relationship or position; e.g., mother, father, child, sibling, physician, detective, etc.

Case Tracking Number: 130920DSP-Milw-377 **Agency:** Bureau of Milwaukee Child Welfare

Child Information (at time of incident)
Age: 2 years Gender: ☐ Female ☒ Male
Race or Ethnicity: Black/African American
Special Needs: None known

Date of Incident: September 20, 2013

Description of the incident, including the suspected cause of death, injury or egregious abuse or neglect:
On September 20, 2013, the agency received a report regarding a 2-year-old boy pronounced dead in his home. Law enforcement responded, the same day, to initiate an investigation into the child's sudden unexplained death. The mother reported that the previous night, the mother's sister came to the home to provide care for the child and his 3-month-old half-sister so the mother could drink. The mother's boyfriend and the mother's adult roommate were also in the home that evening. The mother appeared intoxicated to those responding to the scene, and there were conflicting reports on the amount of alcohol consumed by the mother that night. The maternal aunt reported she went to sleep on the living room floor around midnight while the child and his 1-year-old cousin were sleeping on opposite ends of the couch. The mother reportedly slept on a twin air mattress in her bedroom; the child's half-sister was put to sleep in a pack 'n play and the mother's boyfriend was lying next to the air mattress. The maternal aunt said she woke up briefly in the early morning and saw the child kneeling on the floor with his arms and head on the mother's mattress and he appeared to be sleeping. The aunt reported two or three hours later she went in the bedroom to get the child's younger half-sister and observed the mother pulling the child onto the bed. The mother fed the child's half-sister and then went back to sleep so the aunt took the half-sister out of the bedroom. The mother and the aunt did not notice anything wrong with the child at that time. When the mother woke up a few hours later, she found the child unresponsive. The mother came out of the bedroom and told the aunt something was wrong with the child. They began CPR and called 911. Paramedics responded but were unable to revive the child, and he was pronounced deceased.

On October 22, 2013, the agency learned toxicology results received by the Medical Examiner's Office showed a high level of morphine in the child's system. Law enforcement located a pill bottle containing morphine pills on a shelf of a bedroom closet in the home. Household members denied knowledge of the bottles placement in the closet or how the child could have accessed the drug. The mother later admitted she found the morphine when she moved into the home and kept it. The official cause of the child's death is undetermined by the Medical Examiner's Office, as additional lab reports are pending. Law enforcement's investigation of the child's death is ongoing, and no criminal charges have been filed.

Findings by agency, including maltreatment determination and material circumstances leading to incident:
The agency collaborated with law enforcement and medical professionals to complete the assessment. Based on the information gathered for the Initial Assessment, the agency found a preponderance of the evidence to substantiate neglect by the mother to the child and the child's infant half-sister. The mother knowingly kept the illegal substance morphine in her home and failed to ensure that her children could not access the drug. The agency also substantiated physical abuse to the child by an unknown maltreater. The child sustained a lethal level of morphine in his system; however, the agency was unable to determine how the drug was administered or a specific maltreater. The agency unsubstantiated neglect to the child by the maternal aunt, the mother's boyfriend and the adult roommate because the agency did not find a preponderance of the evidence to conclude they had knowledge of the morphine or administered it to the child. The child's 3-month-old half-sister was determined unsafe in the mother's home and Temporary Physical Custody was taken and the child was placed into out-of-home care.

☒ Yes ☐ No Criminal investigation pending or completed?
☐ Yes ☒ No Criminal charges filed? If yes, against whom?

Child's residence at the time of incident: ☒ In-home ☐ Out-of-home care placement

Complete the appropriate following section (A. or B. based on the child's residence at the time of the incident).

A. Children residing at home at the time of the incident:

Description of the child's family (includes household members, noncustodial parent and other children that have visitation with the child and / or in the child's family home):

Prior to the incident, the child lived with his mother, his three-month-old half-sister and an adult male roommate.

☐ **Yes** ☒ **No** **Statement of Services:** Were services under ch. 48 or ch. 938 being provided to the child, any member of the child's family or alleged maltreater at the time of the incident, including any referrals received by the agency or reports being investigated at time of incident?

If "Yes", briefly describe the type of services, date(s) of last contact between agency and recipient(s) of those services, and the person(s) receiving those services:

N/A.

Summary of all involvement in services as adults under ch. 48 or ch. 938 by child's parents or alleged maltreater in the previous five years: (Does not include the current incident.)

N/A.

Summary of actions taken by the agency under ch. 48, including any investigation of a report or referrals to services involving the child, any member of the child's family living in this household and the child's parents and alleged maltreater. (Does not include the current incident.)

(Note: Screened out reports listed in this section may include only the date of the report, screening decision, and if a referral to services occurred at Access. Reports that do not constitute a reasonable suspicion of maltreatment or a reason to believe that the child is threatened with harm are not required to be screened in for an initial assessment, and no further action is required by the agency.)

On 8/5/2013, the agency screened out a CPS Report.

Summary of any investigation involving the child, any member of the child's family and alleged maltreater conducted under ch. 48 or ch. 938 and any services provided to the child and child's family since the date of the incident:

The agency collaborated with law enforcement and medical professionals to complete the assessment. Based on the information gathered for the Initial Assessment, the agency found a preponderance of the evidence to substantiate neglect by the mother to the child and the child's infant half-sister. The mother knowingly kept the illegal substance morphine in her home and failed to ensure that her children could not access the drug. The agency also substantiated physical abuse to the child by an unknown maltreater. The child sustained a lethal level of morphine in his system; however, the agency was unable to determine how the drug was administered or a specific maltreater. The agency unsubstantiated neglect to the child by the maternal aunt, the mother's boyfriend and the adult roommate because the agency did not find a preponderance of the evidence to conclude they had knowledge of the morphine or administered it to the child. The child's 3-month-old half-sister was determined unsafe in the mother's home and Temporary Physical Custody was taken and the child was placed into out-of-home care. The agency filed a Child in Need of Protection or Services petition regarding the half-sister in juvenile court, and the case was opened to provide ongoing case management services to the family.

B. Children residing in out-of-home care (OHC) placement at time of incident:

Description of the OHC placement and basis for decision to place child there:

N/A.

Description of all other persons residing in the OHC placement home:

N/A.

Licensing history: Including type of license, duration of license, summary of any violations by licensee or an employee of licensee that constitutes a substantial failure to protect and promote the welfare of the child.

N/A.

Summary of any actions taken by agency in response to the incident: (Check all that apply.)

- ☒ Screening of Access report
- ☒ Protective plan implemented
- ☒ Initial assessment conducted
- ☐ Safety plan implemented
- ☒ Temporary physical custody of child
- ☒ Petitioned for court order / CHIPS (child in need of protection or services)
- ☒ Placement into foster home
- ☐ Placement with relatives
- ☐ Attempted or successful reunification
- ☒ Referral to services
- ☐ Transportation assistance
- ☒ Collaboration with law enforcement
- ☒ Collaboration with medical professionals
- ☒ Supervised visitation
- ☒ Case remains open for services
- ☐ Case closed by agency
- ☐ Initiated efforts to address or enhance community

☒ Ongoing Services case management

collaboration on CA/N cases

☐ Other (describe):

FOR DSP COMPLETION ONLY:

Summary of policy or practice changes to address issues identified during the review of the incident:

Under the Child Welfare Disclosure Act (Section 48.981 (7)(cr), Stats.), the DSP completes a 90-Day review of the agency's practice in each case reported under the act. In accordance with the DCF memo Series 2010-13, dated December 7, 2010 pertaining to the Child Welfare Case Review Protocol, the Bureau of Performance Management (BPM) completed a record review in case # 130920DSP-Milw-377. The BPM did not identify practice issues during the review of the incident.

Recommendations for further changes in policies, practices, rules or statutes needed to address identified issues:

None

☒ Yes ☐ No ☐ Not Applicable This 90-day summary report completes the Division of Safety and Permanence (DSP) review of this case.

If the case review was not completed within 90 days, the DSP will complete and submit the final summary report within 6 months.

The agency must submit an electronic copy of the completed 90-Day Summary Report to RobertB.Williams@wisconsin.gov